



What is Economic Assistance?

Economic Assistance programs help low-income individuals, families, children, pregnant women, people with disabilities, and the elderly by providing medical, nutritional, financial, and case management services. You can use this application to apply for Medicaid, the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or any combination of these programs.



When will I get assistance?

- **SNAP** – You will receive SNAP benefits within 30 days if you are eligible. If you are eligible, you will receive benefits within 7 days if you meet one of the following:
 - Households with gross monthly income less than \$150 and resources of \$100 or less.
 - Households with rent, mortgage, and utilities that are more than the household's gross monthly income and resources.
 - Households with migrant or seasonal farm workers with resources of \$100 or less, whose income is stopping or starting.
- **Medical Assistance** – You will receive notice of your eligibility determination within 45 days.
- **TANF** – You will receive notice of your eligibility determination within 30 days.



Apply online

You can apply online for **Medical** and/or **SNAP** assistance at <https://eaportal.sd.gov/>. If applying for **TANF**, you must complete a paper application.



What you may need to apply

- Your Social Security number (or document number if you're an eligible immigrant)
- Employer and income information (for example, from paystubs, W-2 forms, or wage and tax statements)
- Resource information (for example, bank statements, insurance contracts, and other contractual agreements)
- Expense information (for example, rental agreements or utility bills)



Why do we ask for this information?

We ask about income, resource, expense, and other information to let you know what benefits you qualify for.

We'll keep all the information you provide private and secure, as required by law. To view our Notice of Privacy Practices, go to dss.sd.gov/keyresources/hipaa/



What happens next?

YOU HAVE THE RIGHT TO FILE THIS APPLICATION BY COMPLETING JUST YOUR NAME, ADDRESS AND SIGNATURE ON PAGE 3. If eligible, BENEFITS WILL START FROM THE DATE WE RECEIVE YOUR NAME, ADDRESS, AND SIGNATURE on page 3. Mail, fax, or take your application to your local DSS office. If you don't have all the information we ask for, we'll follow up with you. To determine if you are eligible, we must have the full application **and your signature on page 19**. If you're applying for SNAP or TANF, an interview is required. We'll contact you to set up the interview.



Get help with this application

- **Online:** dss.sd.gov
- **Phone:** Call your local office dss.sd.gov/findyourlocaloffice/
- **In person:** Visit your local office dss.sd.gov/findyourlocaloffice/

Tell us about you			
FIRST NAME	MI	LAST NAME	
BIRTH DATE	SOCIAL SECURITY NUMBER		
RESIDENTIAL ADDRESS			
CITY	STATE	COUNTY	ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM RESIDENTIAL ADDRESS)			
CITY	STATE	COUNTY	ZIP CODE
PHONE NUMBER	SECONDARY PHONE NUMBER (OPTIONAL)		
DIRECTIONS TO YOUR HOME (IF NO STREET ADDRESS)			DO YOU LIVE ON AN INDIAN RESERVATION? <input type="checkbox"/> YES <input type="checkbox"/> NO
WHAT IS THE BEST TIME TO CONTACT YOU BETWEEN 8AM AND 5PM?	E-MAIL ADDRESS (OPTIONAL)		

What programs are you applying for?	
<input type="checkbox"/> SNAP <input type="checkbox"/> TANF <input type="checkbox"/> MEDICAL ASSISTANCE	
IF YOU ARE APPLYING FOR TANF (CHECK ALL THAT APPLY): <input type="checkbox"/> MY OWN CHILD(REN). A REQUIRED INTERVIEW WITH AN EMPLOYMENT SPECIALIST WILL BE SCHEDULED WITHIN 2 BUSINESS DAYS OF RECEIVING YOUR APPLICATION. <input type="checkbox"/> A RELATIVE'S CHILD.	IF YOU ARE APPLYING FOR MEDICAL , DO YOU NEED ASSISTANCE PAYING FOR THE PAST 3 MONTHS MEDICAL BILLS OR PREMIUMS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, HOW MANY MONTHS IN THE PAST DO YOU NEED ASSISTANCE? <input type="checkbox"/> ONE <input type="checkbox"/> TWO <input type="checkbox"/> THREE

Do you need interpreter services?	
<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PREFERRED LANGUAGE

Do you need a South Dakota EBT card?	
<input type="checkbox"/> YES <input type="checkbox"/> NO	
If you choose YES or leave blank, an EBT card will be mailed to you and your previous card will not work. If you chose NO, you will not receive an EBT card.	

Signature	
I CERTIFY THAT I WILL GIVE THE SOUTH DAKOTA DEPARTMENT OF SOCIAL SERVICES ALL INFORMATION NEEDED TO REVIEW MY APPLICATION FOR TANF, SNAP, AND MEDICAL ASSISTANCE. THIS INFORMATION WILL BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. SIGNING HERE WILL START YOUR APPLICATION. YOU MUST ALSO SIGN PAGE 19 BEFORE YOU CAN RECEIVE ANY BENEFITS. FOR SNAP AND TANF, YOU MUST COMPLETE THE ENTIRE APPLICATION, HAVE AN INTERVIEW, AND PROVIDE ID TO RECEIVE BENEFITS. IF REQUESTING MEDICAL ASSISTANCE FOR A CHILD, YOUR SNAP INFORMATION WILL BE USED TO DETERMINE THEIR ELIGIBILITY FOR MEDICAL ASSISTANCE UNLESS YOU REQUEST US NOT TO DO SO. IF APPLYING FOR TANF, I ACKNOWLEDGE I AUTOMATICALLY ASSIGN AND TRANSFER ALL CHILD/SPOUSAL SUPPORT RIGHTS TO THE STATE OF SOUTH DAKOTA. I UNDERSTAND I MUST HELP DCS ESTABLISH, MODIFY, OR ENFORCE CHILD SUPPORT FOR THE CHID(REN) IN MY CARE, AND ESTABLISH PATERNITY (IF NECESSARY). THE STATE WILL HAVE THE RIGHT TO ALL UNPAID, PRESENT, AND CONTINUING SUPPORT FOR PERSONS RECEIVING TANF BENEFITS. THE SUPPORT PAYMENTS WILL BE USED TO PAY THE STATE BACK FOR ANY TANF BENEFITS GIVEN. I UNDERSTAND I CAN ASK DSS NOT TO PURSUE CHILD SUPPORT IF IT WOULD ENDANGER ME OR MY CHILDREN.	
SIGNATURE	

Agency use only		
SNAP EXPEDITED: <input type="checkbox"/> YES <input type="checkbox"/> NO	RECEIPT DATE	CASE NUMBER
APPLICATION: <input type="checkbox"/> RENEWAL: <input type="checkbox"/>		

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1. Who lives in your home?

PLEASE LIST EVERYONE IN YOUR HOME, EVEN IF YOU ARE NOT REQUESTING ASSISTANCE FOR THEM.

- COMPLETION OF SOCIAL SECURITY NUMBER AND CITIZENSHIP IS OPTIONAL FOR THOSE NOT REQUESTING ASSISTANCE.
- COMPLETION OF COUNTRY OF BIRTH, MARITAL STATUS, LAST GRADE COMPLETED, SEX, RACE, AND ETHNICITY SECTIONS ARE OPTIONAL AND WILL NOT AFFECT YOUR ELIGIBILITY OR LEVEL OF BENEFITS. THE PURPOSE OF THIS DATA COLLECTION IS TO ASSURE THAT PROGRAM BENEFITS ARE DISTRIBUTED WITHOUT REGARD TO RACE, COLOR, OR NATIONAL ORIGIN.

*Marital Status Codes: N- Never Married/Single M- Married S- Separated D- Divorced W- Widow/ Widower
 ** Race Codes: W- White A- American Indian/Alaska Native B- Black H- Hawaiian/Pacific Islander O- Asian

Check Program below	First Name Middle Initial Last Name	Relation To You (Spouse, Child, Sibling, Friend, etc.)	Social Security Number	Date of Birth	Sex (Check One)	*Marital Status	**Race	U.S. Citizen (Check One)	Does this person prepare and eat meals with you?
				Country of Birth		Last Grade Completed	Ethnicity: (Hispanic or Latino? Check Y or N)		
<input type="checkbox"/> SNAP <input type="checkbox"/> Medical <input type="checkbox"/> TANF <input type="checkbox"/> None		Self			<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	N/A
<input type="checkbox"/> SNAP <input type="checkbox"/> Medical <input type="checkbox"/> TANF <input type="checkbox"/> None					<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> SNAP <input type="checkbox"/> Medical <input type="checkbox"/> TANF <input type="checkbox"/> None					<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> SNAP <input type="checkbox"/> Medical <input type="checkbox"/> TANF <input type="checkbox"/> None					<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> SNAP <input type="checkbox"/> Medical <input type="checkbox"/> TANF <input type="checkbox"/> None					<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> SNAP <input type="checkbox"/> Medical <input type="checkbox"/> TANF <input type="checkbox"/> None					<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> SNAP <input type="checkbox"/> Medical <input type="checkbox"/> TANF <input type="checkbox"/> None					<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> SNAP <input type="checkbox"/> Medical <input type="checkbox"/> TANF <input type="checkbox"/> None					<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> SNAP <input type="checkbox"/> Medical <input type="checkbox"/> TANF <input type="checkbox"/> None					<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

2. Aliases

ARE THERE OTHER NAMES USED BY ANYONE IN THE HOME (MAIDEN NAMES, ALIASES, ETC.)?

YES NO

HOUSEHOLD MEMBER	OTHER NAME(S) USED

3. Immigration Information

IS ANY INDIVIDUAL REQUESTING ASSISTANCE, NOT A U.S. CITIZEN? IF YES, COMPLETE ALL QUESTIONS BELOW.

YES NO

NAME & ALIEN #	DOCUMENT TYPE	DOCUMENT NUMBER	EXPIRATION DATE	LIVED IN U.S. SINCE 1996	ACTIVE U.S. MILITARY OR VETERAN STATUS
				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
				<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

4. Tribal Health Programs (If applying for Medical Assistance)

HAS ANY NATIVE AMERICAN HOUSEHOLD MEMBER RECEIVED A SERVICE OR IS ELIGIBLE TO RECEIVE SERVICES FROM INDIAN HEALTH SERVICES (IHS), URBAN INDIAN HEALTH, OR OTHER TRIBAL HEALTH PROGRAMS?

YES NO

NAME OF HOUSEHOLD MEMBER	NAME OF HOUSEHOLD MEMBER

5. Authorized Representative

DO YOU WISH TO HAVE SOMEONE HELP YOU FILL OUT YOUR APPLICATION, GIVE INFORMATION AT YOUR INTERVIEW AND/OR SPEAK ON YOUR BEHALF AS AN AUTHORIZED REPRESENTATIVE? IF YES, PLEASE COMPLETE THE INFORMATION BELOW.

IF YES, NAME		RELATIONSHIP OR ORGANIZATION
MAILING ADDRESS		
CITY	STATE	ZIP CODE
PHONE NUMBER	E-MAIL ADDRESS	
FOR WHICH PROGRAM(S) SHOULD THIS APPLY?		
<input type="checkbox"/> SNAP <input type="checkbox"/> MEDICAL ASSISTANCE		

6. School Information

DO YOU OR ANYONE IN THE HOME, INCLUDING CHILDREN, ATTEND SCHOOL? IF YES, COMPLETE BELOW.

YES NO

NAME	NAME OF SCHOOL	ENROLLMENT STATUS	EXPECTED GRADUATION DATE	IF THIS IS A BOARDING SCHOOL, DO THEY BOARD?
		<input type="checkbox"/> FULL TIME <input type="checkbox"/> HALF TIME <input type="checkbox"/> LESS THAN HALF TIME		<input type="checkbox"/> YES <input type="checkbox"/> NO
		<input type="checkbox"/> FULL TIME <input type="checkbox"/> HALF TIME <input type="checkbox"/> LESS THAN HALF TIME		<input type="checkbox"/> YES <input type="checkbox"/> NO
		<input type="checkbox"/> FULL TIME <input type="checkbox"/> HALF TIME <input type="checkbox"/> LESS THAN HALF TIME		<input type="checkbox"/> YES <input type="checkbox"/> NO
		<input type="checkbox"/> FULL TIME <input type="checkbox"/> HALF TIME <input type="checkbox"/> LESS THAN HALF TIME		<input type="checkbox"/> YES <input type="checkbox"/> NO

7. Tax Filing Information (If applying for Medical Assistance)

DO **YOU** PLAN TO FILE A FEDERAL INCOME TAX RETURN NEXT YEAR OR WILL YOU BE CLAIMED AS A DEPENDENT ON SOMEONE ELSE'S TAX RETURN NEXT YEAR? IF YES, PLEASE COMPLETE BELOW.

YES NO

WILL YOU FILE JOINTLY WITH A SPOUSE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE LIST THE NAME OF THE SPOUSE
WILL YOU CLAIM ANY DEPENDENTS ON YOUR TAX RETURN? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, LIST THE NAMES OF DEPENDENTS
WILL YOU BE CLAIMED AS A DEPENDENT ON SOMEONE'S RETURN? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE LIST THE NAME OF THE TAX FILER

DOES **ANYONE ELSE** IN THE HOME PLAN TO FILE A FEDERAL INCOME TAX RETURN NEXT YEAR OR WILL ANYONE ELSE BE CLAIMED AS A DEPENDENT ON SOMEONE ELSE'S TAX RETURN NEXT YEAR? IF YES, PLEASE COMPLETE BELOW.

YES NO

NAME	
WILL THEY FILE JOINTLY WITH A SPOUSE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE LIST THE NAME OF THE SPOUSE
WILL THEY CLAIM ANY DEPENDENTS ON THEIR TAX RETURN? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, LIST THE NAMES OF DEPENDENTS
WILL THEY BE CLAIMED AS A DEPENDENT ON SOMEONE'S RETURN? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE LIST THE NAME OF THE TAX FILER

NAME	
WILL THEY FILE JOINTLY WITH A SPOUSE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE LIST THE NAME OF THE SPOUSE
WILL THEY CLAIM ANY DEPENDENTS ON THEIR TAX RETURN? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, LIST THE NAMES OF DEPENDENTS
WILL THEY BE CLAIMED AS A DEPENDENT ON SOMEONE'S RETURN? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE LIST THE NAME OF THE TAX FILER

If additional individuals, please list on separate sheet of paper.

8. Information about Parent(s) Not in the Home

DOES ANY CHILD ON THIS APPLICATION HAVE A PARENT LIVING OUTSIDE THE HOME? IF YES, COMPLETE THE QUESTIONS BELOW.

YES NO

PARENT NAME	CHILD(REN) NAME(S)
PARENT NAME	CHILD(REN) NAME(S)
PARENT NAME	CHILD(REN) NAME(S)

9. Other Parents with Children Living in the Home

OTHER THAN YOU AND YOUR SPOUSE, ARE THERE ANY OTHER PARENTS WITH CHILDREN LIVING IN THE HOME? IF YES, COMPLETE THE QUESTIONS BELOW.

YES NO

PARENT NAME	CHILD(REN) NAME(S)
PARENT NAME	CHILD(REN) NAME(S)
PARENT NAME	CHILD(REN) NAME(S)

10. Pregnancy

IS ANYONE IN THE HOME PREGNANT?

YES NO

NAME	EXPECTED DUE DATE	NUMBER OF BABIES EXPECTED

11. Migrant or Seasonal Farm Worker

IS ANYONE IN THE HOME A MIGRANT OR SEASONAL FARM WORKER?

YES NO

NAME(S)

12. Criminal History

ARE YOU OR ANYONE IN THE HOME HIDING OR RUNNING FROM THE LAW

- TO AVOID PROSECUTION OR FELONY PROSECUTION?
- TO AVOID BEING TAKEN INTO CUSTODY, OR GOING TO JAIL FOR A FELONY OR ATTEMPTED FELONY?
- VIOLATING PAROLE OR PROBATION?

YES NO

NAME(S)

HAS ANYONE IN THE HOME BEEN CONVICTED OF ANY OF THE FOLLOWING AFTER SEPTEMBER 22, 1996

- FRAUDULENTLY RECEIVING DUPLICATE SNAP, TANF, MEDICAL, OR SUPPLEMENTAL SECURITY INCOME (SSI) BENEFITS IN ANY STATE?
- BUYING OR SELLING SNAP BENEFITS OF \$500 OR MORE; TRADING SNAP BENEFITS FOR GUNS, AMMUNITION, EXPLOSIVES, OR DRUGS?

YES NO

NAME(S)

HAS ANYONE IN THE HOME BEEN CONVICTED OF A FELONY AFTER FEBRUARY 7, 2014, AND ARE NOT IN COMPLIANCE WITH THE TERMS OF THEIR SENTENCE OR PAROLE?

YES NO

NAME(S)	STATE WHERE CONVICTED
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13. Activities of Daily Living (If applying for Medical Assistance)

DOES ANYONE IN THE HOME HAVE CONDITIONS THAT CAUSE LIMITATIONS IN DAILY ACTIVITIES (LIKE BATHING, DRESSING, PERSONAL CARE, ETC.)? IF YES, LIST NAME(S) BELOW.

YES NO

NAME(S)

14. Institutions

ARE YOU OR ANYONE IN THE HOME CURRENTLY LIVING IN AN INSTITUTION? IF YES, LIST NAME(S) BELOW. (AN INSTITUTION IS A FACILITY THAT PROVIDES AT LEAST 50% OF MEALS TO YOU SUCH AS ALCOHOL/DRUG TREATMENT CENTER, HOMELESS SHELTER, DOMESTIC VIOLENCE SHELTER, PRISON, ETC.)

YES NO

NAME OF PERSON IN FACILITY	NAME OF FACILITY	
TYPE OF FACILITY	DATE ENTERED	AMOUNT BILLED

15. Assistance in Other States

ARE THERE OTHER STATES/TERRITORIES WHERE YOU OR ANYONE IN THE HOME, INCLUDING CHILDREN, HAVE RECEIVED FOOD, MEDICAL, AND/OR CASH ASSISTANCE? IF YES, COMPLETE BELOW.

YES NO

NAME	BENEFIT TYPE (MED/SNAP/TANF)	COUNTY, STATE/TERRITORY (Contact Number, if known)	START DATE	STOP DATE

16. Tribal Commodities

DO YOU OR ANYONE IN THE HOME RECEIVE TRIBAL COMMODITIES? IF YES, LIST NAME(S) BELOW.

YES NO

NAME(S)

17. Disqualifications

ARE YOU OR ANYONE IN THE HOME DISQUALIFIED FROM RECEIVING SNAP OR TRIBAL COMMODITIES DUE TO AN INTENTIONAL PROGRAM VIOLATION? IF YES, LIST NAME(S) BELOW.

YES NO

NAME(S)

18. Medicare Information (If applying for Medical Assistance)

DO YOU OR ANYONE IN THE HOME HAVE MEDICARE? IF YES, PLEASE COMPLETE BELOW.

YES NO

	YOU	SPOUSE
PLAN TYPE	<input type="checkbox"/> PART A <input type="checkbox"/> PART B <input type="checkbox"/> PART C <input type="checkbox"/> PART D	<input type="checkbox"/> PART A <input type="checkbox"/> PART B <input type="checkbox"/> PART C <input type="checkbox"/> PART D
PART D PLAN NAME (IF APPLICABLE)		
EFFECTIVE DATE		
MEDICARE ID NUMBER		

19. Income from Sources Other Than Employment

DO YOU OR ANYONE IN THE HOME, INCLUDING CHILDREN, RECEIVE MONEY FROM SOURCES OTHER THAN WORK?

*EXAMPLES INCLUDE THE FOLLOWING:

- SOCIAL SECURITY
- SUPPLEMENTAL SECURITY INCOME (SSI)
- RETIREMENT ACCOUNTS
- PENSION FUNDS
- FOSTER CARE, GUARDIANSHIP, ADOPTION FUNDS
- MONEY FROM ANY OTHER SOURCES
- CHILD SUPPORT
- ALIMONY
- WORKER'S COMPENSATION
- UNEMPLOYMENT
- VETERANS' BENEFITS
- RENTAL INCOME
- ANNUITIES
- TRUSTS
- ROYALTIES
- GENERAL ASSISTANCE

YES NO

NAME	TYPE OF INCOME	AMOUNT	HOW OFTEN
		\$	
		\$	
		\$	
		\$	
		\$	
		\$	
		\$	
		\$	
		\$	

* You must provide verification of any income listed above. This may include award letters, benefit statements, rental agreements, etc.

20. Employment Income

DO YOU OR ANYONE IN THE HOME, INCLUDING CHILDREN, HAVE JOB INCOME OR EXPECT TO START A JOB? IF YES, LIST ALL JOB INCOME BELOW AND PROVIDE PROOF OF INCOME FOR THE LAST 30 DAYS.

YES NO

NAME OF PERSON WORKING		EMPLOYER NAME		
EMPLOYER ADDRESS		CITY	STATE	ZIP
EMPLOYMENT TYPE <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> TEMPORARY <input type="checkbox"/> SEASONAL		AVERAGE HOURS WORKED PER WEEK		
WAGES/TIPS (BEFORE TAXES)		HOW OFTEN? <input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> TWICE MONTHLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> OTHER		

NAME OF PERSON WORKING		EMPLOYER NAME		
EMPLOYER ADDRESS		CITY	STATE	ZIP
EMPLOYMENT TYPE <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> TEMPORARY <input type="checkbox"/> SEASONAL		AVERAGE HOURS WORKED PER WEEK		
WAGES/TIPS (BEFORE TAXES)		HOW OFTEN? <input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> TWICE MONTHLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> OTHER		

NAME OF PERSON WORKING		EMPLOYER NAME		
EMPLOYER ADDRESS		CITY	STATE	ZIP
EMPLOYMENT TYPE <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> TEMPORARY <input type="checkbox"/> SEASONAL		AVERAGE HOURS WORKED PER WEEK		
WAGES/TIPS (BEFORE TAXES)		HOW OFTEN? <input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> TWICE MONTHLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> OTHER		

21. Employment that Ended

DO YOU OR ANYONE IN THE HOME HAVE JOB INCOME THAT ENDED IN THE LAST 60 DAYS? IF YES, COMPLETE BELOW AND PROVIDE PROOF OF YOUR FINAL CHECK.

YES NO

NAME	EMPLOYER
LAST DAY WORKED	FINAL CHECK DATE
REASON FOR LEAVING	

22. Strike Participation

ARE YOU OR ANYONE IN THE HOME CURRENTLY ON STRIKE? IF YES, COMPLETE BELOW AND PROVIDE PROOF OF YOUR FINAL CHECK.

YES NO

NAME	EMPLOYER
LAST DAY WORKED	LAST CHECK DATE

23. Work Impairments

ARE YOU OR ANYONE IN THE HOME UNABLE TO WORK DUE TO A HEALTH PROBLEM?

YES NO

NAME	APPLIED FOR SSDI/SSI/VA/WORKER'S COMP?	IF YES, DATE APPLIED
	<input type="checkbox"/> YES <input type="checkbox"/> NO	
	<input type="checkbox"/> YES <input type="checkbox"/> NO	

24. Self-Employment

ARE YOU OR ANYONE IN THE HOME SELF-EMPLOYED OR WORK ODD JOBS FOR CASH?

YES NO

NAME OF SELF-EMPLOYED PERSON	BUSINESS NAME
MONTHLY INCOME	MONTHLY EXPENSES

25. Gambling and Lottery Winnings

HAVE YOU OR ANYONE IN THE HOME RECEIVED GAMBLING OR LOTTERY WINNINGS IN THE PAST 30 DAYS? IF YES, COMPLETE BELOW.

YES NO

NAME	DATE RECEIVED	AMOUNT OF WINNINGS	BALANCE AS OF TODAY

26. Vehicles

DO YOU OR ANYONE IN THE HOME, INCLUDING CHILDREN, OWN OR CO-OWN ANY CARS, TRUCKS, BOATS, OR OTHER RECREATIONAL VEHICLES?

YES NO

OWNER NAME(S)	MAKE/MODEL	YEAR	VALUE	AMOUNT OWED	LEASED
			\$	\$	<input type="checkbox"/> YES <input type="checkbox"/> NO
			\$	\$	<input type="checkbox"/> YES <input type="checkbox"/> NO
			\$	\$	<input type="checkbox"/> YES <input type="checkbox"/> NO
			\$	\$	<input type="checkbox"/> YES <input type="checkbox"/> NO

IF MORE THAN ONE VEHICLE IS LISTED ABOVE, WHICH DO YOU USE AS YOUR PRIMARY METHOD OF TRANSPORTATION?

27. Real Property

OTHER THAN THE HOUSE YOU LIVE IN, DO YOU OR ANYONE IN THE HOME OWN/CO-OWN ANY LAND, BUILDINGS, OR HOMES (INCLUDING MOBILE HOMES)?

YES NO

OWNER NAME(S)		VALUE	AMOUNT OWED	
ADDRESS	CITY	STATE	ZIP	
IS THIS PROPERTY FOR SALE OR RENT?		IF RENTED, DOES THIS PROPERTY PRODUCE INCOME?		
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO		

28. Resources

DO YOU OR ANYONE IN THE HOME, INCLUDING CHILDREN, HAVE ANY RESOURCES? EXAMPLES OF RESOURCES INCLUDE THE FOLLOWING:

- CASH
- CHECKING/SAVINGS ACCOUNTS (*INCLUDING JOINT ACCOUNTS*)
- CERTIFICATES OF DEPOSIT
- SAFETY DEPOSIT BOXES
- RETIREMENT ACCOUNTS
- STOCKS/BONDS/MUTUAL FUNDS
- DIRECT EXPRESS/PAYROLL CARDS
- GOVERNMENT BONDS
- ANNUITIES
- CRYPTOCURRENCIES
- BURIAL PLOTS
- FUNERAL PLANS
- TRUSTS
- LIFE ESTATES
- PROPERTY RIGHTS
- OTHER ITEMS OF VALUE

YES NO

OWNER NAME(S)	TYPE OF RESOURCE	ACCOUNT NUMBER	VALUE	LOCATION, NAME OF BANK, FINANCIAL INST, ETC.
			\$	
			\$	
			\$	
			\$	
			\$	

29. Life Insurance (If applying for Medical Assistance)

DO YOU OR YOUR SPOUSE OWN ANY LIFE INSURANCE POLICIES?

YES NO

NAME OF INSURED PERSON (FIRST NAME, MI, LAST NAME)		NAME OF POLICY OWNER		
POLICY START DATE	FACE VALUE	CASH VALUE		
INSURANCE COMPANY NAME		POLICY NUMBER		
ADDRESS	CITY	STATE	ZIP	

NAME OF INSURED PERSON (FIRST NAME, MI, LAST NAME)		NAME OF POLICY OWNER		
POLICY START DATE	FACE VALUE	CASH VALUE		
INSURANCE COMPANY NAME		POLICY NUMBER		
ADDRESS	CITY	STATE	ZIP	

30. Private Health Insurance (If applying for Medical Assistance)

DO YOU OR YOUR SPOUSE HAVE PRIVATE HEALTH INSURANCE OR MEDICARE SUPPLEMENTAL INSURANCE?

YES NO

NAME OF INSURED PERSON		NAME OF POLICY HOLDER	
INSURANCE COMPANY NAME	POLICY NUMBER	POLICY START DATE	
COMPANY ADDRESS	CITY	STATE	ZIP
HOW MUCH IS THE PREMIUM?	HOW OFTEN IS THE PREMIUM PAID? <input type="checkbox"/> MONTHLY <input type="checkbox"/> QUARTERLY <input type="checkbox"/> YEARLY	TYPE OF COVERAGE (MEDIGAP, RX, ETC)	
DO YOU GET THIS INSURANCE THROUGH AN EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, LIST EMPLOYER'S NAME		

31. Health Insurance History (If applying for Medical Assistance)

HAS ANY HOUSEHOLD MEMBER REQUESTING MEDICAL ASSISTANCE DROPPED HEALTH INSURANCE COVERAGE WITHIN THE LAST 3 MONTHS? IF YES, COMPLETE BELOW.

YES NO

NAME	REASON

32. Resource Transfers

HAVE YOU OR ANYONE IN THE HOME SOLD, TRADED, OR GIVEN AWAY ANYTHING OF VALUE (E.G. MONEY, LAND, VEHICLES, OR BUILDINGS) WITHIN THE LAST 3 MONTHS? IF YES, COMPLETE BELOW.

YES NO

NAME	DATE TRANSFERRED	WHAT WAS TRANSFERRED?	VALUE

33. Shelter Expenses

DO YOU OR ANYONE IN THE HOME PAY FOR SHELTER EXPENSES? IF YES, COMPLETE BELOW AND PROVIDE PROOF OF THE EXPENSE.

YES NO

TYPE	AMOUNT PER MONTH	LANDLORD/BANK NAME & PHONE NUMBER	RENTAL ASSISTANCE/SUBSIDIZED
RENT			<input type="checkbox"/> YES <input type="checkbox"/> NO
LOT RENT			
MORTGAGE			
PROPERTY TAXES			
HOMEOWNER'S INSURANCE			
CONDO FEES			

34. Utility Expenses

DO YOU OR ANYONE IN THE HOME PAY FOR UTILITY EXPENSES? IF YES, COMPLETE BELOW AND PROVIDE PROOF OF THE EXPENSE.

YES NO

ELECTRIC HEAT GAS PROPANE FUEL OIL WOOD HEAT

AIR CONDITIONING GARBAGE WATER ELECTRICITY

SEWER TELEPHONE COOKING FUEL ALL OF THE ABOVE

HAVE YOU OR ANYONE IN THE HOME RECEIVED ANY OF THE FOLLOWING ASSISTANCE IN THE PAST 12 MONTHS? (CHECK ALL THAT APPLY)

ENERGY ASSISTANCE (LIEAP): TRIBAL ENERGY ASSISTANCE: WEATHERIZATION PAYMENTS:

35. Medical Expenses

DOES ANYONE WHO HAS A DISABILITY OR IS AGE 60 OR OLDER, HAVE MEDICAL EXPENSES? EXAMPLES INCLUDE DOCTOR BILLS, PRESCRIPTION DRUGS, EYEGASSES, TRANSPORTATION, INSURANCE PREMIUMS, DENTIST BILLS, ETC. IF YES, COMPLETE BELOW.

YES NO

NAME	HOW MUCH PER MONTH	TO WHOM	HOW OFTEN BILLED
			<input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> OTHER
			<input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> OTHER

36. Child Support & Alimony Expenses

DOES ANYONE IN THE HOME PAY COURT ORDERED CHILD SUPPORT OR ALIMONY TO ANOTHER HOUSEHOLD? IF YES, COMPLETE BELOW AND PROVIDE PROOF OF THE AMOUNT PAID.

YES NO

NAME	HOW MUCH PER MONTH	TO WHOM	HOW OFTEN BILLED
			<input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> OTHER
			<input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> OTHER

37. Dependent Care Expenses

DOES ANYONE IN THE HOME PAY FOR CHILD CARE OR ADULT CARE IN ORDER TO WORK, LOOK FOR WORK, OR ATTEND SCHOOL? IF YES, COMPLETE BELOW AND PROVIDE PROOF OF THE AMOUNT PAID.

YES NO

NAME OF PERSON IN CARE	AMOUNT PAID	HOW OFTEN BILLED	PROVIDER
		<input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> OTHER	
		<input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> OTHER	
		<input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> OTHER	
		<input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> OTHER	

DO ANY OF THE INDIVIDUALS LISTED ABOVE RECEIVE CHILD CARE ASSISTANCE? IF YES, COMPLETE BELOW.

YES NO

NAME(S)

38. Payee or Guardian Expenses

DOES ANYONE IN THE HOME PAY FOR PAYEE SERVICES OR SERVICES FOR A LEGAL GUARDIAN? IF YES, COMPLETE BELOW AND PROVIDE PROOF OF THE AMOUNT PAID.

YES NO

NAME	AMOUNT PAID	HOW OFTEN BILLED	PROVIDER
		<input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> OTHER	
		<input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> OTHER	

39. Tax Deductible Expenses (If applying for Medical Assistance)

DOES ANYONE IN THE HOME PAY FOR CERTAIN THINGS THAT CAN BE DEDUCTED ON A FEDERAL INCOME TAX RETURN (E.G., STUDENT LOAN INTEREST OR TRADITIONAL IRA CONTRIBUTIONS)? IF YES, COMPLETE BELOW AND PROVIDE PROOF OF THE AMOUNT PAID.

YES NO

NAME	AMOUNT PAID	HOW OFTEN BILLED	TYPE OF EXPENSE
		<input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> OTHER	
		<input type="checkbox"/> WEEKLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> OTHER	

40. Help Paying Expenses

DO YOU OR ANYONE IN THE HOME RECEIVE HELP PAYING EXPENSES? IF YES, COMPLETE BELOW. *INCLUDE HELP YOU GET FROM ANY AGENCY, ORGANIZATION, OR PERSON IN PAYING YOUR HOUSEHOLD EXPENSES.*

YES NO

WHICH EXPENSE WAS PAID	NAME OF PERSON WHO PAYS

41. Foster Care (If applying for Medical Assistance)

WERE YOU OR ANYONE IN THE HOME, IN STATE SPONSORED FOSTER CARE AT AGE 18? IF YES, COMPLETE BELOW.

YES NO

NAME	STATE

Statement of Understanding

DSS NOTICE OF NONDISCRIMINATION

The Department of Social Services does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of actual or perceived race, color, religion, national origin, sex, age, or disability in admission or access to, or treatment or employment in its programs, activities, or services. For more information about this policy or to file a Discrimination Complaint you may contact: Discrimination Coordinator, Director of DSS Division of Legal Services, 700 Governor's Drive, Pierre, SD 57501, 605.773.3305

USDA NONDISCRIMINATION STATEMENT

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, religion, sex, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.) should contact the State or local Agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 (voice and TTY). Additionally, program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture,
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW,
Mail Stop 9410
Washington, D.C. 20250-9410; OR

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov

USDA is an equal opportunity provider, employer, and lender.

Would You Like to Register to Vote?

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

YES NO

If you do not check either box, you will be considered to have decided NOT to register to vote at this time.

(Failure to check either box is deemed a declination to register for purposes of receiving assistance in registration but is not deemed a written declination to receive an application. If you do not check either box, you will be provided a voter registration form that you may complete at your convenience.)

If you register to vote, the information regarding the office to which the voter registration form was submitted will remain confidential and be used only for voter registration purposes. If you do not register to vote, this decision will remain confidential and be used only for voter registration purposes. If you would like help filling out the voter registration form, we will help you. The decision whether to seek or accept help is yours. You may fill out the voter registration form in private.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the South Dakota Secretary of State, 500 E Capitol, Pierre SD 57501, (605) 773-3537.

Rights and Responsibilities

- I agree to inform the SD Department of Social Services when
 - my household's income exceeds the maximum amount for my household size; or
 - I or one of my household members is eligible only because of working 20 hours a week and the employment stops or hours decrease to less than 20 hours a week; or
 - I or one of my household members receive lottery or gambling winnings over \$4,500 (for SNAP) or \$2,000 (for TANF), before taxes or other deductions are withheld. Winnings must be reported within 10 days of their receipt.
- I understand that if I am approved for SNAP/TANF benefits and meet the criteria to be a six-month reporter, that I am required to report changes that may affect my level of benefits and/or eligibility for SNAP/TANF programs. I understand that if I do not complete the six-month report by the deadline noted on the form, my benefits may be delayed or end. (The report form will be mailed automatically in the 5th month of your certification period.)
- If receiving Medical Assistance, I agree to inform the SD Department of Social Services if the number of persons living with me or a pregnancy status changes, if there is a change in income, tax filing status changes, or a change in insurance.
- I understand that by applying for and accepting medical assistance, I assign any proceeds or any other third-party support, for each person for whom medical coverage was requested, to the SD Department of Social Services.
- I understand that if any child on this application has a parent living outside the home, I will be asked to cooperate with the agency that collects medical support from a parent not living in the home. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid, and I may not have to cooperate.
- I understand that if any of my children on this application has a parent living outside the home, I will be asked to cooperate with the agency that collects child support from a parent not living in the home for SNAP and TANF eligibility. If I do not cooperate, I understand I will not be eligible for SNAP and/or TANF benefits. If I think that cooperating to collect child support will harm me or my children, I can tell my Benefits Specialist, and I may not have to cooperate.
- I understand I have the right to appeal if my SNAP and/or TANF application is not acted on within 30 days or my medical application is not acted on within 45 days by Economic Assistance.
- I understand I have the right to appeal within 90 days, if I disagree with any action made regarding my SNAP benefits. I also understand that I have the right to appeal within 30 days if I disagree with any decision made regarding my TANF and/or Medical Assistance application.
- Federal and state laws and regulations limit the use and disclosure of confidential or protected health information about applicants and recipients of assistance programs.
- Social Security numbers must be provided for all members applying for or receiving assistance. (Public Law 104-193 governing TANF, authorized under the Food and Nutrition Act of 2008 as amended through Public Law 110-246, and ARSD 67:46:01:12 governing Medical Assistance): Individuals applying for assistance may request help in obtaining Social Security numbers. Social Security numbers will not be shared with Federal immigration. Social Security numbers and all other information provided will be used or disclosed in order to determine eligibility and benefit level, prevent duplicate participation, verify the accuracy of information provided, verified through computer cross matches with other Federal and State agencies (Department of Labor, Social Security, Internal Revenue Service, etc.) when a discrepancy is found, assist in collection of benefit overpayments, used for program compliance and management, and apprehend persons fleeing to avoid the law, if requested.
- I understand that I must inform my Benefits Specialist if I have been convicted of an Intentional Program Violation (IPV) for any benefit program, whether the conviction was in South Dakota or any other state.
- I understand that I only have to provide immigrant status for individuals asking for or receiving benefits. However, individuals are still required to answer questions and submit verification about income and resources which may affect eligibility and benefits. An individual's immigration status will be verified if he/she applies for and/or receives benefits. Verification will be obtained by USCIS (U.S. Citizenship & Immigration Services) and may affect household's eligibility and level of benefits.
- I understand that I will receive a written notice explaining the benefits I will receive. If benefits are denied, changed, suspended, or stopped, the written notice will explain why.
- I understand that information provided, and information obtained by DSS through computer cross-matching with other agencies (Dept. of Labor and Regulation, Internal Revenue Services, Social Security Administration, etc.), employers, financial sources, and other third parties will be used and may be verified when discrepancies are found and may affect my household's eligibility and level of benefits.

Penalties	
IF YOU DO THE FOLLOWING...	YOU WILL...
<ul style="list-style-type: none"> ▪ Hide information or make false statements ▪ Use SNAP benefits that belong to someone else ▪ Use SNAP benefits to buy alcohol or tobacco ▪ Trade or sell SNAP benefits, South Dakota EBT cards, or groceries purchased with SNAP benefits 	Lose SNAP and/or TANF benefits for: <ul style="list-style-type: none"> ▪ 12 months for the first offense ▪ 24 months for the second offense ▪ Permanently for the third offense ▪ May be referred for criminal prosecution
<ul style="list-style-type: none"> ▪ Trade SNAP benefits for controlled substances such as drugs 	Lose SNAP benefits for: <ul style="list-style-type: none"> ▪ 24 months for the first offense ▪ Permanently for the second offense
<ul style="list-style-type: none"> ▪ Trade SNAP benefits for firearms, ammunition, or explosives ▪ Trade, buy, or sell SNAP benefits of \$500 or more 	Lose SNAP benefits permanently
<ul style="list-style-type: none"> ▪ Give false information when applying for or receiving assistance 	<ul style="list-style-type: none"> ▪ Be fined up to \$1000 or sentenced up to 12 months in county jail, or both, if convicted of a misdemeanor ▪ Be fined up to \$2000 or sentenced up to 2 years in prison, or both, if convicted of a felony
<ul style="list-style-type: none"> ▪ Give false information with respect to the identity or place of residence in order to receive multiple SNAP benefits simultaneously 	<ul style="list-style-type: none"> ▪ Lose SNAP benefits for 10 years.
<ul style="list-style-type: none"> ▪ Give false information affecting eligibility of Medical Assistance 	<ul style="list-style-type: none"> ▪ Lose Medical Assistance up to a year ▪ Be fined up to \$5000 or sentenced up to 5 years in prison, or both, if convicted
<p>You can also be fined up to \$250,000 or sentenced to prison up to 20 years, or both, for doing these things. You may also be charged under other Federal or State programs and could be ordered to repay the cost of that assistance. You may also be barred from receiving SNAP for an additional 18 months if court ordered. You can also be charged with perjury.</p>	
Sign and Authorize Application (Required)	
<ul style="list-style-type: none"> • I give my consent for any person, agency, or institution to supply information to the Department of Social Services, about me or my household, and to allow inspection and copying of records about me or my household by any representative of the Department. • I authorize the Department to release information to providers, state, and/or federal agencies. • I release any person, agency, or institution from any liability to me or my household for supplying such information. • This consent is given only for use by the Department in the administration of its benefit programs. <p>I understand that the information on this form is subject to verification by Federal, State, and local officials to determine that such information on this application is correct and complete including citizenship and alien status of the members applying for benefits. If any information is found to be incorrect, benefits may be reduced or terminated, and I will be responsible for paying the benefits back. I declare and affirm under penalties of perjury that this application has been examined by me and to the best of my knowledge and belief is in all things true and correct. I understand I may be subject to criminal prosecution for knowingly providing incorrect information. I have read and understand the legal information and understand my rights and responsibilities and agree to fulfill them. I understand the penalties for giving false information or breaking the rules of the assistance program(s). I agree that I will give the South Dakota Department of Social Services all information needed to review my application for assistance and that this information will be true and correct.</p>	
<hr/>	
SIGNATURE OF APPLICANT	
SIGNATURE OF AUTHORIZED REPRESENTATIVE	

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Authorization to Furnish/Release Information

All adult household members should read and sign this Authorization to Furnish/Release Information form. This form may be used to help verify information you provide to process your application. If you need additional copies of this form, please contact your local office, or download the form from the website at: <https://dss.sd.gov/formsandpubs/docs/MEDELGBLTY/208AuthorizationReleaseInformation.pdf>

Case Name: _____

To Whom it May Concern:

I give my consent for any person, agency, or institution to supply information to the Department of Social Services, about me or my household, and to allow inspection and copying of records about me or my household by any representative of the Department.

I authorize the Department to release information to providers, state, or federal agencies.

I release any person, agency, or institution from any liability to me or my household for supplying such information.

This consent is given only for use by the Department in administration of its benefit programs.

Signature of Applicant/Recipient Date

Signature of Spouse/Guardian Date

Signature of Other Adult Household Member Date

Address

City/State/Zip Code

Telephone Number

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Appendix A: American Indian or Alaska Native (AI/AN) Household Members

American Indian or Alaska Native Family Member (AI/AN)

Complete this appendix if you or a family member is American Indian or Alaska Native and you are requesting Medical Assistance.

Tell us about your American Indian or Alaska Native family member(s).

American Indians and Alaska Natives can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

	AI/AN PERSON 1	AI/AN PERSON 2	
1. Name (First Name, Middle Name, Last Name)	First	First	
	Middle	Middle	
	Last	Last	
2. Member of a federally recognized tribe?	Yes <input type="checkbox"/> If yes, tribe name: _____	Yes <input type="checkbox"/> If yes, tribe name: _____	
3. Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Certain money received may not be counted for Medicaid or the Children's Health Insurance Program (CHIP). List any income (amount and how often) reported on your application that includes money from these sources: Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations) Money from selling things that have cultural significance	\$ _____ How often? _____	\$ _____ How often? _____	
AI/AN PERSON 3	AI/AN PERSON 4	AI/AN PERSON 5	AI/AN PERSON 6
First	First	First	First
Middle	Middle	Middle	Middle
Last	Last	Last	Last
Yes <input type="checkbox"/> If yes, tribe name: _____	Yes <input type="checkbox"/> If yes, tribe name: _____	Yes <input type="checkbox"/> If yes, tribe name: _____	Yes <input type="checkbox"/> If yes, tribe name: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, is this person eligible to get services from the Indian Health Service, tribal health programs, or urban Indian health programs, or through a referral from one of these programs? <input type="checkbox"/> Yes <input type="checkbox"/> No
\$ _____ How often? _____	\$ _____ How often? _____	\$ _____ How often? _____	\$ _____ How often? _____

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Economic Assistance Helpful Reminders

PLEASE KEEP THIS SECTION FOR YOUR RECORDS!

Information for SNAP:

- You **must** report to the Department of Social Services (DSS) when:
 - Your household income exceeds the maximum amount for your household size; **or**
 - You or one of your household members is eligible only because of working 20 hours a week and the employment stops or hours decrease to less than 20 hours a week; **or**
 - You or one of your household members receive lottery or gambling winnings of \$4,500 or more (before taxes or other deductions). Winnings must be reported within 10 days of their receipt.
- If you have received lottery or gambling winnings of \$4,500 or more, you will immediately be ineligible for SNAP. You will remain ineligible until you again meet the allowable resource and income eligibility limits.
- If eligible, you are entitled to one SNAP benefit per month. If you apply after the 15th of the month, and determined eligible, you may receive the first and second months' benefits at the same time.
- If you receive the wrong amount of benefits, you will have to pay them back.
- Your case may be subject to a Federal or State audit whether it is active or not.
- You cannot receive SNAP benefits and commodities in the same month unless the commodities are distributed through the Senior Box Program.
- If you are able to work, you must register for work and cooperate with work registration requirements. Failure to cooperate will result in disqualification. Quitting a job or voluntarily reducing employment hours, without good cause, may also result in disqualification.
- If you meet the definition of an Able Bodied Adult Without Dependents (ABAWD) and are able to work but not currently working, you may only be eligible for benefits for 3 months out of a 36-month time period unless you meet exemption criteria explained by your Benefits Specialist.
- You can spend SNAP benefits like cash at authorized stores for food and for edible garden plants or seeds to grow food to eat. You cannot buy alcohol, tobacco, vitamins, medicine, pet food, paper products, or hot foods prepared for immediate consumption with your SNAP benefits.
- You are not allowed to pay for food purchased on credit with SNAP benefits. If you do, you may lose benefits.
- The SD EBT card, benefits, or food purchased with the SD EBT card cannot be sold or traded. **It is against the law.** If benefits and/or food purchased with SNAP benefits are sold or traded, it will be investigated and if found guilty, a 12 month, 24 month, or permanent disqualification for SNAP will be implemented and the amount of any misused benefits will be required to be repaid. Individuals may also be referred for criminal prosecution which could result in a fine and/or prison time.
- Once you've received your benefits, you can use them right away. We recommend you use your South Dakota EBT (SD EBT) card at least once every 30 days. If your case closes, you can still use any benefits remaining in your account for up to 9 months. The card may be used anywhere in the United States where EBT is accepted.
- You will have to choose a PIN number for your SD EBT card. This PIN should be easy for you to remember but hard for someone else to figure out. If you cannot remember your PIN write the PIN down at home and keep it in a safe place until you are ready to shop. **DO NOT** write your PIN on your card or keep it in your wallet, purse, or with your EBT card. If you tell someone your PIN and give them your card, they could use **ALL** your benefits, and these benefits will not be replaced if this happens.
- The SD EBT card will last for years. It is important to keep the SD EBT card in a safe and secure location. If your SD EBT card is lost, stolen or damaged, you must call EBT customer service at **1-800-604-5099** to order a replacement. A replacement card will be mailed to you within 5-7 days. Make sure DSS has your current mailing address prior to ordering a replacement EBT card. Excessive request for replacement cards will be investigated.
- Funds taken from the SD EBT card must be for the exact amount of the purchase. You should not be charged sales tax on purchases made with SNAP benefits.
- If your SNAP case closes, your household may continue to be eligible for other assistance such as TANF and/or Medical.
- A copy of your application is available to you either in paper or electronic format.

Information for TANF:

- You must report to DSS when your household income exceeds the maximum amount for your TANF household size.
- You must report if you or one of your household members receive lottery or gambling winnings over \$2,000, before taxes or other deductions are withheld. Winnings must be reported within 10 days of their receipt.

Information for SNAP & TANF:

- Information reported to your Benefits Specialist the first of the month or later will not change benefits until the following benefit month(s).
- Children receiving SNAP or TANF benefits are automatically eligible for the National School Lunch Program if it is offered at the school the child attends.
- If required, you must complete a report form six months after application. The form will be automatically sent to you in the 5th month of your certification. If you do not complete the report form by the date listed on the form, your benefits may be delayed or end. If you need assistance in completing the form, contact a Benefits Specialist.
- Your SNAP and/or TANF benefits may be reduced or stopped if you do not cooperate with the TANF work program.

Information for Medical programs:

- After approval, for **ALL** questions regarding covered medical services or billing issues please call – **1-800-597-1603**. You may also refer to the medical recipient handbook.
- After medical approval, to change your primary care provider, you can call your Benefits Specialist OR you can stop by your local DSS office to request the change. Remember, your request will not take effect until the 1st of the next month.

General Information for All programs:

- Social Security numbers (SSN) must be provided for all household members over the age of 6 months if you want benefits for the individual. Infants 7 months or older without a SSN must provide proof that a SSN has been applied for or the infant will be ineligible for benefits until the SSN is provided or proof of application is received.
- All adult household members should read and sign an Authorization to Furnish/Release Information. This form is included in the application, on page 21, for the applicant, spouse, and any other adult household members. If additional signatures are needed, an additional form will be provided.
- Please make sure we have your most current mailing address because mail from the Department of Social Services is **NOT** forwarded by the Post Office.
- You must inform your Benefits Specialist if you or any other household member has been convicted of an Intentional Program Violation (IPV) for any benefit program, whether the conviction was in South Dakota or any other state.
- You only have to provide immigrant status for individuals asking for or receiving benefits. However, individuals are still required to answer questions and submit verification about income and resources which may affect eligibility and benefits. An individual's immigration status will be verified if he/she applies for and/or receives benefits. Verification will be obtained by USCIS (U.S. Citizenship & Immigration Services) and may affect household's eligibility and level of benefits.
- You will receive a written notice explaining the benefits you will receive. If benefits are denied, changed, suspended, or stopped, the written notice will explain why.
- Information you provide and information obtained by DSS through computer cross-matching with other agencies (Dept. of Labor and Regulation, Internal Revenue Services, Social Security Administration, etc.), employers, financial sources, and other third parties will be used and may be verified when discrepancies are found.
- If you wish to appeal our decision to reduce, deny, or close benefits, you may request a fair hearing by writing any office in the Department of Social Services or send your written request directly to the Office of Administrative Hearings, Kneip Building, 700 Governors Drive, Pierre, SD 57501-2291. For SNAP only, you may make your request by calling any local Department of Social Services office or the office of Administrative Hearings at 1-605-773-6851.